addresshealth
Healthy children. Happy children.

ANNUAL SCHOOL HEALTH CHECK - SCREENING QUESTIONNAIRE

Name of School: ______________________________

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Instructions to parents for filling up the questionnaire

1. This information is vital for your child's health record. This information will not be shared with anyone, except the school authorities, where required.
2. Please fill ONLY those sections that are relevant for your child. Other sections can be left blank.
3. Please refer to Doctor's prescription/ Hospital Summary/ Immunization Card before filling the details

CHILD IDENTIFIER DETAILS

Child's Name		Blood Group	
Date of Birth		Class & Section	
Gender	☐ Boy ☐ Girl	ID Card / Roll Number	

IN CASE WE NEED TO CONTACT YOU

• Father • Mother • Guardian (Please Select One)	Mobile No										

YOUR CHILD'S PEDIATRICIAN/PHYSICIAN

Doctor's Name:											
Mobile Number:											Email ID:

IMMUNIZATION HISTORY

Age	Vaccine	Status
Below 2 Years	As per Indian Immunization Schedule	• Yes • No • Don't Know
If vaccine(s) was/were missed, please provide details, on which ones		
If your child is older than 5 years, have you given	DTP Booster MMR Varicella/ Chicken Pox Typhoid	• Yes • No • Don't Know • Yes • No • Don't Know • Yes • No • Don't Know • Yes • No • Don't Know
If your child is older than 10 years have you given	Tdap/ Td HPV (For girls only)	• Yes • No • Don't Know • Yes • No • Don't Know

MEDICATION & ALLERGY HISTORY

If your child takes any **medicines on a daily basis**, prescribed **by a doctor**, please provide the details below

Name of Medicine	Dosage & Route of administration	For What Medical Condition is it being given

Our services:

Infirmary | Health Education | Health Check-up | Nurturing Schools

ALLERGY HISTORY If your child has a **known allergy, diagnosed by a doctor**, please provide the details below

What is your child allergic to (e.g pollen, peanuts)_1	
What is your child allergic to (e.g pollen, peanuts)_2	

HOSPITAL ADMISSION HISTORY

If your child ever had a medical illness, surgery or injury which required hospital admission, please provide details?

Month / Year	Nature of Illness that required Hospital Admission

HEALTH HISTORY - Please tick the medical conditions your child has ever been diagnosed by your child's doctor

Medical Conditions		
• Asthma/ Wheeze/Allergic Bronchitis	• Seizures / Epilepsy / Fits	• Anaemia • Bleeding Disorders
• Diabetes	• Bone & Joint Problem • Fractures	• Tuberculosis
• Frequent Urinary Infections	• Kidney Ailments	• Skin problems
• Frequent Ear Discharge	• Hearing problems	• Autism
• Physical Disabilities	• Neurological problems	• Heart Disease
• Learning Disabilities	• Speech Difficulties	• Attention Deficit Hyper-activity Disorder (ADHD)

OTHER GENERAL HEALTH SCREENING QUESTIONS

Question	
Has your child ever complained of chest pain?	• Yes • No
Has your child ever complained of dizziness or has ever fainted?	• Yes • No
Has your child ever felt breathless on climbing one flight of steps?	• Yes • No
Has your child ever complained of frequent headaches?	• Yes • No
Has your child ever had any sudden abnormal weight/height changes?	• Yes • No
Has your child ever had a history of a sudden change in appetite?	• Yes • No
Did your child ever receive any blood transfusions?	• Yes • No
Did your child ever have a history of pain or swelling in the joints?	• Yes • No

OTHER HEALTH ISSUES: Any other concern about your child's health that you would like to share:

Caveat & Consent: AddressHealth has been contracted by your child's school to conduct an annual health check-up of children. This agreement will be treated as an implied consent from the parent for assessing the health status of their child. Please note that this consent is only to screen, evaluate and suggest remedies. No medications or vaccinations will be administrated and no surgeries or invasive tests will be performed during this programme. The health screening process uses population screening tools that have been validated, through third party research. These tools have a high sensitivity & medium-high specificity. This may result in false positive diagnosis from time to time. In simple terms, screening results are not a final diagnosis and need a full individual follow up with a qualified medical professional.

Signature of Parent / Guardian ______________________ **Date:** ___/___/______

Toll Free No.: 1800-425-9355

www.addresshealth.com | info@addresshealth.com | facebook.com/AddressHealth